MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

63-029364 STATE FILE NUMBER

Registration District No. 264 Primary Registration District No. 5988 Registrar's No. 77

FILED JUL 22 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Ozark
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Big Creek Twp.
Length of stay in 1b: 10 years
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location)
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Ozark
c. CITY OR TOWN: Theodosia
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Big Creek Twp
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Winford Middle: Lawrence Last:

4. DATE OF DEATH: Month: July Day: 15 Year: 1963

5. SEX: M
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 3-4-1887
9. AGE (last birthday): 76
IF UNDER 1 YEAR / IF UNDER 24 HR: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (City and state or country): Big Flat Ark.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Will Lawrence
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: Bertrude

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of serv
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Harold Bookout Address: Council Bluff Iowa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: One hour.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from ____ to ____ and last saw her/him alive on ____
Death occurred at 7: P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M. L. Hoerman Co Coroner
22b. ADDRESS: Gainesville Mo.
22c. DATE SIGNED: 7-18-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-17-63
23c. NAME OF CEMETERY OR CREMATORY: Hicks
23d. LOCATION (City, town, or county) (State): Ozark Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: C. A. Kingsbeard Gainesville
25. DATE RECD. BY LOCAL REG.: 7-20-63
26. REGISTRAR'S SIGNATURE: Barbara Shaw

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Ware

Licensed Embalmer No. 4885

P. O. Address Gainesville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.